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# POCKET BOOK for Family Planning



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# POCKETBOOK

## for Family Planning







# ACKNOWLEDGEMENTS

Family planning services providers need to continuously update themselves with the latest medical developments. While the government issues guidelines for all available contraceptives in the public health domain and provides a vast array of information online, providers have expressed the need for a ready reckoner in the form of a single booklet or pocketbook with all critical information. With support from the Ministry of Health and Family Welfare of the Government of India and other technical experts, EngenderHealth led development of this pocketbook to respond to this expressed need.

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# HEALTHY TIMING AND SPACING OF PREGNANCY

## What is healthy timing and spacing of pregnancy (HTSP)?

Healthy timing and spacing of pregnancy (HTSP) is a way of achieving healthier pregnancies and deliveries through adequate timing and spacing (preferably 2-year intervals) to reduce pregnancy-related risks to the health of mothers and babies.

## What is family planning (FP)?

Family planning (FP) involves planning the number, frequency, and timing of pregnancies. FP is achieved through use of various methods.

## What are the 3 key messages I should discuss with clients for HTSP?

The 3 key messages to discuss with clients to achieve the healthiest pregnancy outcomes for mother and baby are:

1. *After a live birth:* Clients should wait (use an effective FP method of choice continuously) for at least 2 years, but not more than 5 years, before trying to become pregnant again.
2. *After a miscarriage or abortion:* Clients should wait (use an effective FP method of choice continuously) for at least 6 months after a miscarriage or abortion, before trying to become pregnant again.
3. *For adolescents and youth:* Adolescents and youth should avoid pregnancy until they are at least 18 years old, by using an effective FP method of their choice continuously.

## What happens when HTSP messages are not considered?

When HTSP messages are not considered, there is a risk of babies being born too small, too soon, with too low birth weights, and they are more likely to die before the age of 5. The mother also risks developing life-threatening complications, such as preeclampsia, premature rupturing of the membrane, anemia, and even death.

## When should I discuss a client's reproductive intentions?

Appropriate times for discussing a client's reproductive intentions include:

- During antenatal care (checkups before delivery)

- During postpartum care (checkups after delivery)
- At admission for cesarian or labor management
- During child immunizations sessions
- During FP services provision
- During abortion and postabortion care
- During services related to sexually transmitted infections (STIs) (including HIV) and reproductive tract infections
- During services for any diseases
- During services to adolescents and youth
- During community outreach events

### When counseling clients for HTSP, what should I prioritize?

1. Explain HTSP messages to clients clearly, using language that they understand and emphasizing the importance of avoiding pregnancies *“too young, too old, too close, too soon.”*
2. Explain that in order to time and space pregnancies, clients can use effective FP methods of their choice.
3. Discuss the range of FP methods available.
4. Explain how clients can obtain and use FP methods.
5. Emphasize the health, social, and economic benefits of practicing HTSP.
6. Remind the clients that HTSP benefits the whole family.
7. Encourage clients to ask questions and share information with partners, family members, and friends.

## What is an ideal contraceptive method?

A contraceptive method should be safe, effective, easy to use, readily available and accessible, inexpensive, with minimal or no side effects, and responsive to the needs, preferences, and circumstances of the client.

An illustration of a man and a woman in a rural setting. The woman, on the left, is wearing a yellow sari and has her hand on the man's shoulder. The man, on the right, is wearing a light-colored shirt and is smiling. In the background, there is a simple house with a thatched roof and a tree. The overall style is a soft, yellow-toned line drawing.

# **Family Planning Methods Available in Public Health Facilities**



# COMBINED ORAL CONTRACEPTIVES (MALA-N)

## What are combined oral contraceptives (COCs)?

Combined oral contraceptives (COCs) are pills that are taken once a day to prevent pregnancy. COCs contain low doses of the hormones estrogen and progesterone (ethyl estradiol 30 mcg and levonorgestrel 0.15 mg). COCs are commonly known as “the pill,” “oral contraceptive pills or OCPs” and “Mala-D or Mala-N,” the latter being brand names.

## How effective are COCs?

The effectiveness of COCs depends on the user.

- As typically used, (with a degree of human error), approximately 7 pregnancies occur per 100 clients using COCs in the first year.
- When properly used, less than 1 pregnancy occurs per 100 COC clients (3 per 1,000 clients) in the first year.
- Fertility returns immediately after COCs are discontinued.

## How do COCs work?

COCs work primarily by preventing the release of eggs from the ovaries (ovulation).

## Who can use COCs?

- Clients who want an effective, reversible method
- Clients of any age, including adolescents and those over 40 years of age
- Clients experiencing anemia due to heavy menstrual bleeding and menstrual cramps
- Clients with irregular menstrual cycles
- Clients with a family history of ovarian cancer
- Clients living with HIV, including those using antiretrovirals

## Who should not use COCs?

- Breastfeeding clients who are less than 6 months postpartum and non-breastfeeding clients who are less than 3 weeks postpartum
- Clients with long-standing diabetes, hypertension, heart disease, liver disorders, unexplained vaginal bleeding, migraines, blood clots in the legs or lungs, and smokers over 35 years should only be prescribed COCs with the advice of a clinician





## What are the benefits of COCs?

- Reversible, easy to use, and safe for most clients
- Regulates the menstrual cycle and reduces menstrual flow, hence improves anemia and reduces menstrual cramps and ovulation pain
- May protect against ovarian and uterine cancer, benign breast disease, and acne
- Decreases incidence of pelvic inflammatory disease
- Does not interfere with sexual intercourse
- Immediate return of fertility upon discontinuation

## What are the side effects of COCs?

The side effects of COCs, which are temporary and not dangerous, include:

- Headache
- Nausea

- Changes in bleeding patterns, including light bleeding, bleeding between menses, and/or irregular bleeding
- Weight change
- Breast tenderness

### What are the limitations of COCs?

- COCs must be taken every day.
- COCs do not protect against STIs, including HIV.
- COCs increase the risk of cardiovascular disease in smokers over 35 years of age.

### When may clients start using COCs?

- Any time during the menstrual cycle, if it is reasonably certain that the client is not pregnant
- Within 5 days of the start of monthly bleeding (Note: If starting COCs more than 5 days after the start of monthly bleeding, use of a backup method, such as condoms or abstinence, for the first 7 days is required.)
- Postpartum, fully breastfeeding: 6 months after delivery
- Postpartum, not breastfeeding: Between days 21 and 28 after delivery
- Postabortion, including induced abortion or miscarriage: Immediately (Note: If starting 7 days after an abortion, use of a backup method is required.)

### How are COCs used?

The client will take 1 pill each day:

- *For 28-pill packets* (with 21 hormonal pills and 7 inactive pills containing iron): The day after finishing 1 packet, the client should take the first pill from the next packet.
- *For 21-pill packets* (with 21 hormonal pills): After finishing 1 packet, the client should wait 7 days before taking the first pill from the next packet.

### How should a client manage missed pills?

- *Missed 1 or 2 COCs or started a new pack 1 or 2 days late:* Take a pill as soon as possible and then continue taking pills daily, 1 each day.
- *Missed 3 or more COCs in the first 2 weeks or started a pack 3 or more days late:* Take a pill as soon as possible and continue taking pills daily, 1 each day. Clients should use a backup method until they have taken pills for 7 days in a row. If clients miss 3 or more pills in the third week, they should finish the hormonal pills in the current pack and start a new pack the next day (i.e., do not take the 7 inactive pills) and use a backup method for 7 days. Note, this may result in a missed period, and that is okay. If the client has had sex in past 3 days (72 hours), consider the need for emergency contraception.
- *Missed 1 or more of any inactive pills:* Discard the missed pill(s), and take the rest of the pills as usual (1 per day), and then start a new packet as usual.

### Do COCs provide protection from STIs, including HIV?

No, COCs do not provide protection from STIs, including HIV.

## Clarifying Myths and Misconceptions

**Question 1:** Should I take rest from COCs after taking them for some time?

**Answer:** No, taking rest is not needed. In fact, taking a rest from COCs can lead to unintended pregnancies. COCs can be used for many years without needing periodic breaks.

**Question 2:** Will COCs make me infertile, after I stop taking them? How long will it take for me to become pregnant after stopping COCs?

**Answer:** You are protected from pregnancy as long as you take the pill regularly. Clients who stop using COCs can become pregnant quickly. It only takes 1 to 3 months for fertility to return to normal after discontinuing the COCs.

**Question 3:** Do COCs cause abortion?

**Answer:** No, COCs do not disrupt an existing pregnancy. They should not be used to try to cause an abortion; they will not do so.

**Question 4:** Will becoming pregnant while on the pill lead to birth defects?

**Answer:** A baby will not have birth defects if a client becomes pregnant while using COCs or if a client who is already pregnant accidentally starts to take COCs.

**Question 5:** Will the pill make me gain weight?


**Answer:** Most clients do not gain or lose weight due to COCs. Weight changes naturally as life circumstances change and as people age. Some COC clients experience sudden weight changes, but these changes usually reverse after clients stop taking COCs.

**Question 6:** Will the pill change my mood or sex drive?

**Answer:** Although some clients blame the pill for mood swings, depression-like symptoms, and irritability, studies have found no evidence that COCs affect mood or sex drive. Most COC users do not report any such changes; however, some report improvements in both mood and sex drive.

**Question 7:** Will COCs increase my risk of cancer?

**Answer:** COCs actually reduce the risks of ovarian and endometrial cancer. However, some studies have shown that breast cancer is slightly more common among COC users and those who have used COCs in the past 10 years compared to other clients.



# WEEKLY ORAL PILLS: CENTCHROMAN (CHHAYA)

## What are weekly oral pills or centchroman?

Weekly oral pills, commonly known as centchroman, and also known as ormeloxifene, are nonsteroidal, nonhormonal once-a-week oral contraceptive pills. They are available in public health facilities as “Chhaya” and are also available over the counter as “Saheli.”

## How effective is centchroman?

It is highly effective, if taken regularly. With perfect use, the failure rate reported is 1 to 2 pregnancies per 100 clients; there is no data available for typical use.

## How does centchroman work?

Centchroman acts as selective estrogen receptor modulator. It works by creating asynchrony between a developing zygote and endometrial maturation. This means it changes the response of different body

parts to estrogen, thus delaying the maturation of the endometrial lining while hastening transportation of the fertilized egg, which prevents implantation.

### Who can use centchroman?

- Clients who want an effective, reversible method
- Clients who want to use oral contraception but not hormonal methods
- Clients who are breastfeeding
- Clients of any age, including adolescents and those over 40 years of age
- Clients with anemia
- Clients who have recently experienced an abortion, miscarriage, or ectopic pregnancy
- Clients living with HIV, including those using antiretrovirals

### Who should not use centchroman?

- Clients with polycystic ovarian disease
- Clients with cervical hyperplasia
- Clients with a recent history of or if there is clinical evidence of jaundice or liver disease
- Clients with severe allergic states or chronic illnesses (such as tuberculosis or renal diseases)



### What are the benefits of centchroman?

- Highly effective among breastfeeding clients (99%)
- Reversible, easy to use, and safe for most clients
- Can be started soon after childbirth
- Can be used while breastfeeding
- Does not interfere with sexual intercourse
- Can be provided by trained nonmedical staff
- Immediate return of fertility upon discontinuation

### What are the side effects of centchroman?

There are almost no side effects. Centchroman causes delayed periods in some clients; but this occurs in only 8% of users (approximately) and usually only lasts for the first 3 months (periods tend to settle into a rhythm once the body becomes used to the medication). Periods may also become sparse over time in some clients.



## When may clients start using centchroman?

Clients may start centchroman any time it is reasonably certain that they are not pregnant. If the client is starting within 5 days of the start of monthly bleeding, there is no need for a backup method.

Postpartum clients can start any time after delivery for up to 4 weeks; this applies to both breastfeeding and non-breastfeeding clients.

In cases of first and second trimester abortions, clients can start immediately after surgical abortion, or on the third day following medical abortions (i.e., when Misoprostol is given).

## How is centchroman used?

The first pill is taken on the first day of the client's monthly bleeding and the second pill is taken 3 days later. The client will repeat this pattern for the first 3 months.

Starting in the fourth month, the client will take a pill once a week on the first day of monthly bleeding and continue taking one pill on the same day of the week each week regardless of their menstrual cycle.

## How should a client manage missed pills?

- Take a pill as soon as possible after it is missed.
- For a missed pill taken within 7 days, the client should continue with the normal schedule but use a backup method until the next period starts.

- For a pill missed by more than 7 days, the client will need to start over again as a new user, taking a pill twice a week for 3 months and then once a week.

## Does centchroman provide protection from STIs, including HIV?

No, centchroman does not provide protection from STIs, including HIV.

## Clarifying Myths and Misconceptions

### Question 1: Is Chhaya safe for me, as I am breastfeeding?

**Answer:** Chhaya, or centchroman, is a good choice for breastfeeding clients who want to use pills. Chhaya is safe for both mother and baby, starting immediately after birth, and it does not affect milk production.

### Question 2: Can I continue taking centchroman when I stop breastfeeding my baby?

**Answer:** Yes. A client who is satisfied with using centchroman can continue using it after she has stopped breastfeeding.

### Question 3: Does centchroman cause birth defects? Will the fetus be harmed if I accidentally take centchroman while pregnant?


**Answer:** No, evidence shows that centchroman does not cause birth defects. It does not harm the fetus if taken accidentally while pregnant or if a client becomes pregnant while taking centchroman.

**Question 4:** Will Chhaya cause any serious side effects?

**Answer:** Apart from occasionally prolonging the menstrual cycle, this nonhormonal contraceptive pill is not known to cause any other side effects, (such as nausea, weight gain, fluid retention, or hypertension, which are commonly seen with combined oral contraceptives, COCs).

**Question 5:** Does centchroman cause vaginal discharge, spotting, breakthrough bleeding, or prolonged or heavy bleeding?

**Answer:** No, centchroman does not cause vaginal discharge, spotting, breakthrough bleeding, or prolonged or heavy bleeding (menorrhagia).



# INJECTABLE CONTRACEPTIVES (ANTARA)

## What are injectable contraceptives?

Injectable contraceptives are injected into the muscle (intramuscular injection) or the subcutaneous tissue (subcutaneous injection) every 3 months to prevent pregnancy. The injection contains medroxyprogesterone acetate (MPA). These are progestin-only injectables and do not contain any estrogen.

## How effective are injectable contraceptives?

Injectable contraceptives are 99.7% effective in perfect use and 97% effective in typical use (meaning, the failure rate for perfect use is 0.3% and for typical use is 3%). When clients receive injections on time, the failure rate is less than 1 pregnancy per 100 clients in the first year (4 per 1,000 clients). Fertility returns approximately 4 months after the client's last injection, which is longer than most other methods.

## How do injectable contraceptives work?

Injectable contraceptives work by preventing the release of eggs from the ovaries (ovulation).

## Who can use injectable contraceptives?

- Clients with or without children
- Clients who are married or unmarried
- Clients of any age, including adolescents and those older than 40
- Clients who are breastfeeding (starting as soon as 6 weeks after delivery)
- Clients who have recently had an abortion or miscarriage
- Clients who smoke cigarettes, regardless of age or number of cigarettes smoked
- Clients living with HIV, including those using antiretrovirals

## Who should not use injectable contraceptives?

- Clients who are breastfeeding a baby less than 6 weeks old
- Clients with active liver disease (severe cirrhosis of the liver, a liver infection, or liver tumor)
- Clients with systolic blood pressure 160 or higher or diastolic blood pressure 100 or higher
- Clients who have had diabetes for more than 20 years or with damage to arteries, vision, kidneys, or the nervous system

- Clients with a history of heart attack, heart disease due to blocked or narrowed arteries, or stroke or with current blood clot(s) in the deep veins of the leg or in the lung(s)
- Clients with unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition
- Clients who currently have or who have a history of breast cancer



## What are the benefits of injectable contraceptives?

- Highly effective, if taken regularly
- Reversible, easy to use, and safe for most clients
- Helps protect against endometrial cancer (cancer of the lining of uterus) and uterine fibroids
- May help protect against symptomatic pelvic inflammatory disease and iron deficiency (anemia)
- Reduces sickle cell crises among clients with sickle cell anemia and symptoms of endometriosis (pelvic pain and irregular bleeding)

- Can be taken with medications for tuberculosis and epilepsy
- Does not interfere with sexual intercourse
- Is given in private (other people will not know that the client is using this method without the client's disclosure)

## What are the side effects of injectable contraceptives?

The side effects of injectable contraceptives include:

- Changes in bleeding patterns, including irregular or infrequent bleeding, prolonged bleeding, or no monthly bleeding
- Weight gain (approximately 1 to 2 kg per year) (Note: Some weight gain may be related to other factors, such as aging, and some clients may lose weight or not experience any significant weight change.)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Decreased sex drive
- Slight loss of bone density, with some increased risk of osteoporosis after menopause (Note: The World Health Organization has concluded that this decrease in bone density does not indicate a need for age or time limits on usage.)

## When can clients start injectable contraceptives?

Clients may start injectable contraceptives any time it is reasonably certain that they are not pregnant.

- *Clients with regular monthly bleeding:*
  - ▶ May start within 7 days of the start of monthly bleeding
  - ▶ May start more than 7 days after the start of monthly bleeding, but a backup method is required for the first 7 days following the injection
- *For postpartum clients:*
  - ▶ If fully or nearly fully breastfeeding and monthly bleeding has not returned: Begin 6 weeks after giving birth or any time between 6 weeks and 6 months, if monthly bleeding has not returned; if it is more than 6 months, ensure the client is not pregnant and note that a backup method is required for the first 7 days
  - ▶ If breastfeeding and monthly bleeding has returned: Use as advised for clients with regular monthly bleeding
  - ▶ If not breastfeeding and within 4 weeks of birth: Begin any time
  - ▶ If not breastfeeding and after 4 weeks: If monthly bleeding has not returned, begin any time it is reasonably certain that the client is not pregnant; a backup method is required for the first 7 days; if monthly bleeding has returned, use as advised for clients with regular monthly bleeding



## How are injectable contraceptives used?

Injectable contraceptives are typically injected in the upper and outer part of the arm, the thigh, or the upper and outer part of the buttock. Inform clients of the name of the injection and instruct them not to massage the injection site and to return in 3 months (13 weeks) for the next injection. Repeat injections can be given up to 2 weeks early, or up to 4 weeks late, without the need for a backup method, but it is best to return on time.

## Do injectable contraceptives provide protection from STIs, including HIV?

No, injectable contraceptives do not provide protection from STIs, including HIV.

## Clarifying Myths and Misconceptions

### **Question 1:** Do injectable contraceptives cause nausea?

**Answer:** No, nausea is not common with injectables. In fact, many clients using injectable contraceptives find their appetite becomes stronger.

### **Question 2:** Will breastfeeding clients continue to produce adequate milk while using injectables?

**Answer:** Injectable contraceptives do not effect the quantity or composition of breast milk, initiation or duration of breastfeeding, or the growth and development of the infant.

### **Question 3:** Is amenorrhea bad for the mother's health?

**Answer:** Amenorrhea (the absence of monthly bleeding) is an expected side effect of injectable contraceptives because

these contraceptives prevent ovulation. This kind of amenorrhea is not harmful. In fact, it helps prevent anemia and frees clients from the discomfort and inconvenience of monthly bleeding.

**Question 4:** Does MPA cause abnormal or deformed babies?

**Answer:** There is no evidence that injectable contraceptives cause any abnormalities in infants.

**Question 5:** Do clients need to take rest periods after several injections?

**Answer:** No. There is no limit to the number of years clients can continuously use injectable contraceptives.

**Question 6:** Do injectable contraceptives cause abortion?

**Answer:** No, injectable contraceptives do not cause abortion. Injectable contraceptives prevent ovulation. If no egg is released, no fertilization takes place; hence, no pregnancy can occur and therefore there is no abortion.

**Question 7:** Do injectable contraceptives result in retained menses causing blood toxicity?

**Answer:** No, injectable contraceptives prevent ovulation but do not lead to blood retention and toxicity.

**Question 8:** Do injectables cause onset of menopause?

**Answer:** No, injectable contraceptives do not cause menopause. The amenorrhea experienced only occurs during use and normal menstruation will return when the injections stop.



# MALE CONDOMS

## What is a male condom?

A male condom is a thin sheath, usually made of latex rubber, that is placed on an erect penis before intercourse. Condoms are also known as “rubbers,” “raincoats,” “umbrellas,” “skins,” and “prophylactics.”

## What are the types of male condoms available?

Most are made of latex rubber; however, polyurethane condoms are also available for individuals allergic to latex.

## How effective are male condoms?

Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used properly with every act of sexual intercourse. When used correctly and with every sex act, the male condom has a failure rate of approximately 2 pregnancies per 100 clients in the first year. As typically used, the failure rate is approximately 15 pregnancies per 100 clients in the first year.

## How do male condoms work?

Condoms serve as barriers that block semen (and thus sperm) from entering the vagina, thereby preventing pregnancy. They also prevent infections in semen, on the penis, or in the vagina from infecting the other partner.

## Who can use male condoms?

All clients and can safely use male condoms, except for those who are, or whose partners are, allergic to latex rubber (although these individuals may use polyurethane condoms).

## Who should not use male condoms?

Clients who are, or whose partners are, allergic to latex should not use latex condoms.

## What are the benefits of male condoms?

- Inexpensive and easily available
- Provide dual protection against pregnancy and STIs
- Help protect against conditions caused by STIs, such as recurring pelvic inflammatory disease and chronic pelvic pain, cervical cancer, and infertility (male and female)
- Immediate return of fertility upon discontinuation



## What are the side effects of condoms?

Very rarely, people with latex allergies may experience severe allergic reactions.

## When can clients use male condoms?

Clients may use male condoms any time.

## How are male condoms used?

1. Use a new condom for each sexual act.
  - Check the condom package. Do not use the condom if the package is torn, damaged, or expired.
  - Open the package carefully. Do not use fingernails, teeth, or anything that could damage the condom.
2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side facing out.
  - For the most protection, put the condom before the penis makes any genital, oral, or anal contact.

3. Unroll the condom all the way to the base of the penis.
  - The condom should unroll easily; forcing it may cause it to break during use.
  - If the condom does not unroll easily, it may have been placed on backwards or it may be damaged or too old. Throw it away and use a new condom. If it is on backwards and a new condom is not available, turn it over and unroll it onto the penis.
4. Immediately following ejaculation, hold the rim of the condom in place and withdraw the penis while still erect.
  - Withdraw the erect penis.
  - Slide the condom off the penis while facing away from your partner and avoid spilling semen.
  - If you will be having sex again or are switching between different sex acts, use a new condom.
5. Dispose of the used condom safely.
  - Wrap the condom in its package or a tissue and place it in the rubbish. Do not put condoms in flush toilets, as they can cause problems with plumbing.

### Do male condoms provide protection from STIs, including HIV?

Male condoms significantly reduce the risk of STIs, including HIV, when used properly and with every individual act of sex. They protect against STIs spread by fluids or discharge as well as STIs spread by skin-to-skin contact (such as herpes).

## Clarifying Myths and Misconceptions

**Question 1:** Do male condoms make men sterile, impotent, weak, or decrease their sex drive?

**Answer:** Condoms do not make men sterile, impotent, weak, or decrease their sex drive.

**Question 2:** Can male condoms get lost in a person's body?

**Answer:** No, condoms cannot get lost inside a person's body.

**Question 3:** Do condoms have holes in them through which HIV can pass and infect my partner?

**Answer:** No, condoms do not have holes through which HIV can pass. In fact, condoms (male and female) are the only contraceptive that protects against STIs, including HIV.

**Question 4:** Do condoms cause people to become ill?

**Answer:** Condoms do not cause people to become ill unless they are allergic to the material (latex rubber).

**Question 5:** Will condoms cause my sperm to “get backed up” and cause me to become ill.

**Answer:** Condoms do not cause sperm to “get backed up” (and will not cause you to become ill); sperm still leave the body through semen, as with other methods, but remain inside the condom.

**Question 6:** Are male condoms only for young clients?

**Answer:** No, condoms can be used by anyone who wishes to prevent pregnancy and STIs, including HIV.



# COPPER INTRAUTERINE CONTRACEPTIVE DEVICE

## What is a copper intrauterine contraceptive device (IUCD)?

A copper IUCD, also known simply as an IUCD and as an intrauterine device or IUD, is a small, flexible device made of plastic formed in a “T” or inverted “U” shape and wrapped in copper wire with 2 long strings that hang through the cervix into the vagina.

There are 2 types of copper IUCDs available:

1. *IUCD 380A*, which is effective for up to 10 to 12\* years (*\*according to recent international guidance*)
2. *IUCD 375*, which is effective for up to 5 years

## How effective are copper IUCDs?

Copper IUCDs are highly effective in providing long-term, reversible contraception. The failure rate is less than 1 pregnancy per 100 clients in the first year and approximately 2 pregnancies per 100 clients over 12 years.

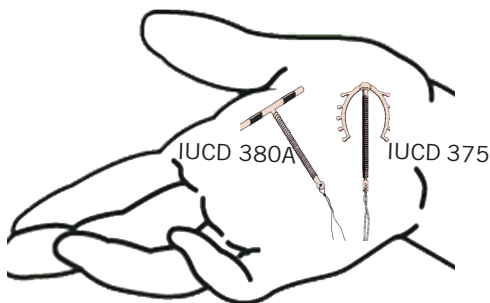


## How do copper IUCDs work?

Copper ions alter the uterine and tubal environment to decrease sperm function and prevent sperm from reaching the fallopian tubes and from fertilizing an egg.

## What are the benefits of copper IUCDs?

- Highly effective (98 to 99%)
- Reversible, easy to use, and safe for most clients
- Long-acting: provides protection for up to 12 years
- Effective immediately after insertion
- Can serve as emergency contraceptive if inserted within 5 days of the first act of unprotected sexual intercourse
- Can be replaced, without any gap, as many times as desired, during a client's reproductive life
- Convenient, does not require user attention once inserted
- Does not interfere with sex



- Can be used while breastfeeding
- Nonhormonal: Does not interact with other medications that the client may be taking
- Immediate return of fertility upon discontinuation

### What side effects, health risks, and complications are associated with copper IUCDs?

The primary *side effect*, which is temporary and not dangerous, is a change in bleeding patterns (especially in the first 3 months). This includes:

- Prolonged and heavy monthly bleeding
- Irregular bleeding
- More cramping and pain during monthly bleeding

There are also a couple of *potential risks*, including:

- Expulsion of IUCD
- Displacement of IUCD

Other, *less common health risks* include:

- Uncommon:
  - ▶ May contribute to anemia in clients who have low iron blood stores before insertion, as the IUCD may cause heavier monthly bleeding
  - ▶ Infection (Note: The infection rate following insertion is less than 1% and is typically due to lack of proper technique.)
- Rare:
  - ▶ Pelvic inflammatory disease may occur in clients with chlamydia or gonorrhea at the time of insertion

*Complications*, which are rare, include:

- Puncturing (perforation) of the wall of the uterus by the IUCD or an instrument used for insertion; this is rare (occurs in 0.5 to 1.5 per 1,000 insertions and is associated with the level of provider's skill and experience) and usually heals without treatment
- Miscarriage, preterm birth, or infection in the rare case that the client becomes pregnant while the IUCD is in place

### When can a client have a copper IUCD inserted?

- *Interval*: Any time within the first 12 days of the start of monthly bleeding or any time after 12 days, if it is reasonably certain that the client is not pregnant
- *Postpartum*: Any time within 48 hours of delivery or after 4\* to 6 weeks of delivery (\*according to recent international guidance)
- *Postabortion*: Immediately after an abortion or within 12 days, if no infection is present; beyond 12 days after an abortion, any time if it is reasonably certain that the client is not pregnant

### How are copper IUCDs used?

A trained provider inserts the copper IUCD into the uterus. Depending on type of copper IUCD, a client can keep the IUCD for up to 5 or 12 years; however, a provider can remove it any time the client desires.

### When should a client return for follow-up care?

Copper IUCD users should see a provider for a routine

checkup 3 to 6 weeks after insertion or at their first menstruation, whichever is earlier. Subsequent follow-up care is recommended 3 and 6 months afterwards. (Note: Recent international guidance recommends only one follow-up visit after the first menstrual period or 3 to 6 weeks following insertion.)

Clients may seek emergency follow-up care any time, if problems develop. Clients experiencing any of the following should see a provider:

- Period-related problems or pregnancy symptoms
- Abdominal pain or pain during intercourse
- Infection or unusual vaginal discharge
- Illness, such as fever or chills
- String problems

### Do copper IUCDs provide protection from STIs, including HIV?

No, copper IUCDs do not provide protection from STIs, including HIV.

### Clarifying Myths and Misconceptions

**Question 1:** Can an IUCD travel through my body, for example, to my heart or brain?

**Answer:** No, IUCDs usually stay in the uterus until removed by a provider. If an IUCD does come out by itself, it comes out through the vagina. IUCDs cannot move to the heart or brain.

**Question 2:** Do copper IUCDs prevent pregnancy by causing abortion?

**Answer:** Copper IUCDs work by preventing sperm from fertilizing an egg, rather than by destroying a fertilized egg. Therefore, there is no risk of pregnancy or abortion.

**Question 3:** Do copper IUCDs cause discomfort during sex for either me or my partner?

**Answer:** As the IUCD is located inside the uterus, not the vaginal canal, neither the client nor the partner will feel it during sex. The partner may feel the strings, but this can be easily corrected if it becomes a problem.

**Question 4:** Will the copper IUCD rust inside my body?

**Answer:** The copper IUCD will not rust inside the body, even after many years.

**Question 5:** Do copper IUCDs increase the risk of pregnancy outside the uterus (ectopic pregnancies)?

**Answer:** The copper IUCD reduces the risk of ectopic pregnancy by preventing all pregnancies. Because copper IUCDs are so effective at preventing pregnancy overall, they offer excellent protection against ectopic pregnancies.

**Question 6:** Do copper IUCDs increase my risk of STIs or cause pelvic inflammatory disease, and will it need to be removed if I need treatment.

**Answer:** The copper IUCD does not increase the risk of STIs. While pelvic inflammatory disease is a potential risk, the IUCD does not need to be removed for treatment.

**Question 7:** Do copper IUCDs cause infertility?

**Answer:** Copper IUCDs do not cause infertility. In fact, most clients conceive soon after removal.

**Question 8:** Are IUCDs an option for clients without children?

**Answer:** Yes, nulliparous clients (clients without children) can use copper IUCDs.

**Question 9:** Can clients who are living with HIV use IUCDs?

**Answer:** Clients living with HIV who are clinically well can generally use copper IUCDs.

**Question 10:** Do copper IUCDs cause cancer?

**Answer:** Copper IUCDs do not cause cancer. Rather, studies have found that IUCD use reduces the risk of endometrial cancer and that the IUCD may also offer protection against cervical cancer.

**Question 11:** Will IUCDs cause birth defects in my next baby?

**Answer:** Copper IUCDs do not cause any birth defects.

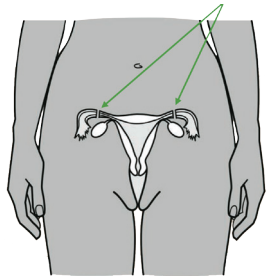
# FEMALE STERILIZATION

## What is female sterilization?

Female sterilization is a safe, permanent surgical procedure for contraception for clients who do not want more children.

There are 2 surgical approaches:

- *Minilaprotomy*, or minilap requires a small incision in the abdomen through which a provider will ligate and cut or block the fallopian tubes.
- *Laparoscopy* also requires a small incision and involves inserting a long, thin tube with a lens into the abdomen through the incision to enable the provider to see and block the fallopian tubes by placing a small silicone ring around a loop of the fallopian tubes.



Tubes cut/ blocked here

## How effective is female sterilization?

Female sterilization is highly effective immediately following the procedure, with less than 1 pregnancy per 100 clients in the first year (5 per 1,000).

## How does female sterilization work?

Female sterilization involves blocking or cutting the fallopian tubes, preventing any eggs released from the ovaries from moving through the tubes and joining with any sperm that may enter.

## Who can undergo female sterilization?

With proper counseling and informed consent, any woman can safely obtain female sterilization. Per national guidelines, sterilization clients should fulfill the following criteria:

- Be ever-married
- Be over the age of 22 and below the age of 49
- Have at least 1 child, who is at least 1 years old (unless medical sterilization is indicated)
- Not have undergone sterilization (or have a spouse who has undergone sterilization) previously (except in the case of failed sterilization)
- Be of sound mind (able to understand the full implications of sterilization)

## Who cannot undergo female sterilization?

No medical condition prevents a client from using female



sterilization and the procedure can be performed in a routine setting. However, some medical conditions may limit when, where, or how the procedure should be performed. Such situations may require using caution, delaying the procedure, and/or making special arrangements.

- *Caution* means the procedure can be performed in a routine setting, but with extra preparations.
- *Delay* means postpone the procedure until after certain conditions may be treated and resolved. The client should use a backup method of choice in the interim.
- *Special* means special arrangements are required to perform the procedure, for example, in a setting that offers an experienced surgeon and staff, equipment to provide general anesthesia, and other medical support.

For a complete list of medical conditions that necessitate caution, delay, and special arrangements, refer to the National Guidelines on Female Sterilization.

### When can female sterilization be performed?

Female sterilization can be performed at the following times:

- *With regular monthly bleeding:* Within 7 days of the start of monthly bleeding or any time it is reasonably certain that the client is not pregnant
- *Following childbirth:* Within 48 hours of delivery
- *Following a miscarriage (spontaneous abortion):* Concurrently or within 7 days, after ensuring that the abortion is complete and excluding infection
- *Following a surgical abortion:* Immediately after the

procedure or within 48 hours, after ensuring that the abortion is complete and excluding infection

- *Following a medical abortion:* During the next menstrual cycle
- *Without monthly bleeding:* Any time it is reasonably certain the client is not pregnant

### What are the benefits of female sterilization?

- Highly effective, permanent protection against pregnancy
- Convenient: No need for any further user action after the procedure is complete
- Helps protect against pelvic inflammatory disease
- May help protect against ovarian cancer

### Are there any health risks or complications associated with female sterilization?

Although uncommon, there is a slight risk of complications related to surgery and anesthesia. If performed by a trained provider using appropriate techniques and in an appropriate setting, the risk of such complications is extremely rare.

### How do providers perform female sterilization?

- Provide comprehensive counseling on the procedure before obtaining voluntary consent. Obtain a written consent in a language that the client understands. Comprehensive counseling must cover the following to ensure informed consent:
  - ▶ Temporary contraceptives are also available.
  - ▶ Sterilization is a surgical procedure.

- ▶ There are both risks and benefits to sterilization.
  - ▶ If successful, the procedure will prevent the client from ever having more children.
  - ▶ The procedure is considered permanent and likely cannot be reversed.
  - ▶ The client may decide against having the procedure at any time before the procedure occurs.
  - ▶ Sterilization does not protect against STIs, including HIV.
- Instruct clients to not have fluids for 2\* to 4 hours prior to surgery and to not have solid food for 6 to 8\* hours prior to surgery (*\*according to recent international guidance*). Clients may consume food and beverages immediately after the procedure.
  - Instruct clients not to take any medications 24 hours prior to surgery, except as directed. Oral tablets and injections may be required in advance.
  - Complete a physical examination of the client.
  - Inject a local anesthetic at the site of surgery.
  - For *minilaparotomy*, make small incision (3 to 5 cm); identify, tie, and cut the fallopian tubes; and close the incision. The whole procedure will take approximately 15 to 20 minutes.
  - For a *laparoscopic tubal ligation*, use a device called laparoscope to occlude the tubes. (Note: This procedure cannot be done during the postpartum period.)
  - After the procedure, observe the client for 4 to 6 hours at the clinic or hospital.

- Before discharge, provide the following instructions:
  - ▶ Rest for the remainder of the day; resume light work only after 48 hours at the earliest.
  - ▶ Avoid heavy weight lifting for 1 week.
  - ▶ Avoid putting pressure or tension on the incision for 1 week.
  - ▶ Wait 1 week before returning to full activities.
  - ▶ Avoid sex for at 1 week; resume sex only after it is comfortable to do so.
  - ▶ Use medications as instructed; take antibiotics only if and as advised.
  - ▶ Resume a normal diet as soon as possible.
  - ▶ Keep the incision area clean and dry.
  - ▶ Do not disturb or open the dressing.
  - ▶ Bathe 24 hours following the surgery, but if the dressing becomes wet, change it to keep the incision area dry until the stitches are removed.
- Provide the following instructions for routine and emergency follow-up care:
  - ▶ Report to the doctor or clinic in the event of excessive pain, fainting, fever, bleeding or other discharge from the incision, inability to pass urine, or inability to pass flatus while experiencing bloating in the abdomen.
  - ▶ Return to the clinic for a pregnancy test if there is a missed period or a suspected pregnancy within 2 weeks of a missed period.

- ▶ Establish contact with healthcare worker within 48 hours for routine care; return for a follow-up visit 7 days after the surgery, or as early as possible after 7 days, and return for a second follow-up visit after 1 month or if menses do not return.

## Does female sterilization provide protection from STIs, including HIV?

No, female sterilization does not provide protection from STIs, including HIV.

## Clarifying Myths and Misconceptions

**Question 1:** Will sterilization change or stop my monthly bleeding?

**Answer:** No, sterilization will not affect your monthly bleeding.

**Question 2:** Will I lose my sexual desire or gain weight after sterilization?

**Answer:** No, after sterilization you should look and feel the same as before. You can have sex the same as before, and you may find that you enjoy sex more because you do not need to worry about becoming pregnant. You will not gain weight because of the sterilization procedure.

**Question 3:** Can I become pregnant again after sterilization?

**Answer:** Generally no. Female sterilization is very effective at preventing pregnancy and is intended to be permanent. It is not 100% effective, however, so clients have a slight risk of becoming pregnant.

**Question 4:** Can the procedure be reversed if I decide I want another child?

**Answer:** Generally no. Female sterilization is intended to be permanent. If you may want more children, please consider nonpermanent contraceptive methods. Surgery to reverse sterilization is possible for only some clients, it is difficult and expensive, and providers who are able to perform such surgery are hard to find. Thus, sterilization should be considered irreversible. Also, a pregnancy that occurs after a reversal, poses a higher risk of being ectopic than other pregnancies.

**Question 5:** Does female sterilization increase the risk of ectopic pregnancy?

**Answer:** No. Female sterilization greatly reduces the risk of ectopic pregnancy by preventing any pregnancy. Ectopic pregnancies are very rare among clients who have undergone sterilization.

**Question 6:** Does female sterilization lead to lasting pain in the abdomen, back, or uterus?

**Answer:** Sterilization does not lead to lasting pain in the abdomen, back, or uterus.

**Question 7:** Does female sterilization involve removing the uterus?

**Answer:** No, female sterilization does not involve removing the uterus or lead to a need to remove the uterus.

# MALE STERILIZATION

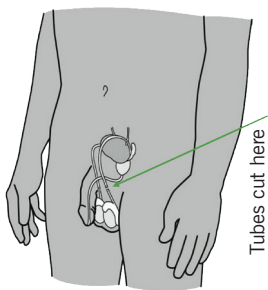
## What is male sterilization?

Male sterilization is a safe, simple, and permanent surgical procedure for clients who do not want more children.

## How effective is male sterilization?

Male sterilization is one of the most effective contraceptive methods. However, it is not fully effective until 3 months after the procedure.

Where clients *are able* to have their semen examined to determine sperm content, pregnancy rates are less than 1 per 100 in the first year (2 per 1,000). Where clients *are unable* to have their semen examined, pregnancy rates are approximately 2 to 3 per 100 in the first year.



## How does male sterilization work?

Male sterilization involves closing of vas deferentia, thereby keeping sperm out of semen. The ejaculated semen will not have any sperm, so it cannot cause pregnancy.

## Who can undergo male sterilization?

With proper counseling and informed consent, any man can safely obtain male sterilization. Per national guidelines, sterilization clients should fulfill the following criteria:

- Be ever-married
- Have at least 1 child, who is at least 1 years old
- Be over the age of 22 and below the age of 60
- Not have undergone sterilization (or have a partner who has undergone sterilization) previously (except in the case of failed sterilization)
- Be of sound mind (able to understand the full implications of sterilization)

Further, male sterilization is possible for clients who:

- Have sickle cell disease
- Are at high risk of HIV or other STI infection, or are living with HIV (including if they are using antiretrovirals)

## When can male sterilization be performed?

Male sterilization can be performed any time, as requested.

## Who should not undergo male sterilization?

There are no contraindications for male sterilization; however, some medical conditions may limit when, where,



or how the procedure should be performed. Such situations may require using caution, delaying the procedure, and/or making special arrangements.

- *Caution* means the procedure can be performed in a routine setting but with extra preparations.
- *Delay* means postpone the procedure until after certain conditions may be treated and resolved. The client should use a backup method of choice in the interim.
- *Special* means special arrangements are required to perform the procedure, for example, in a setting that offers an experienced surgeon and staff, equipment to provide general anesthesia, and other medical support.

For a complete list of medical conditions that necessitate caution, delay, and special arrangements, refer to the National Guidelines on Male Sterilization.

### What are the benefits of male sterilization?

- Highly effective, permanent protection against pregnancy
- Removes the burden of ongoing contraception, thereby increasing enjoyment of sex for both partners

### Are there any complications or health risks associated with male sterilization?

While rare, the following are potential complications of male sterilization:

- Severe scrotal or testicular pain
- Infection at procedural site
- Bleeding under the skin causing swelling (hematoma)

## How is male sterilization performed?

Male sterilization involves puncturing or making a small incision in scrotum (under local anesthesia) and blocking the vas deferentia by tying and cutting.

Before the procedure, provide comprehensive counseling on the procedure before obtaining voluntary consent. Obtain a written consent in a language that the client understands. Comprehensive counseling must cover the following to ensure informed consent:

- Temporary contraceptives are also available.
- Sterilization is a surgical procedure.
- There are both risks and benefits to sterilization.
- If successful, the procedure will prevent the client from ever having more children.
- The procedure is considered permanent and likely cannot be reversed.
- The client may decide against having the procedure at any time before the procedure occurs.
- Sterilization does not protect against STIs, including HIV.

After the procedure is completed, provide the following instructions:

- Rest for 2 days, if possible.
- Wait to resume normal work for 48 hours and to return to full activity (including cycling) for 7 days.
- Apply a cold compress to the scrotum for the first 4 hours, if possible.

- Wear snug underwear or pants for 2 to 3 days.
- Do not have sex for at least 2 to 3 days; resume sex thereafter when it feels comfortable.
- Keep the area around the puncture or incision clean and dry; remove the dressing after 48 hours.
- Resume a normal diet as soon as possible.
- Use a backup method for 3 months, until all sperm are cleared from the system.
- Return after 3 months for a semen analysis, if available.

### Does male sterilization provide protection from STIs, including HIV?

No, male sterilization does not provide protection against STIs, including HIV.

### Clarifying Myths and Misconceptions

**Question 1:** Will male sterilization make me lose my sexual ability? Will it make me weak, thin, or fat?

**Answer:** No, after sterilization you should look and feel the same as before. You can have sex the same as before. Your erections will be as hard and last as long as before, and your ejaculations will be the same (they will contain semen but not sperm). You will not gain or lose weight or become weak because of sterilization.

**Question 2:** Will I have severe or long-lasting pain from male sterilization?

**Answer:** Severe, long-lasting pain following male sterilization is uncommon, but there are potential risks as well as remedies for treating such pain.

**Question 3:** Do I need to use another contraceptive method after sterilization?

**Answer:** Yes, for the first 3 months. This is because the distal segment of the vas deferentia will still contain some sperm, and it will take 3 months to expel that sperm. Not using another method during this time is the main cause of pregnancies among clients relying on male sterilization.

**Question 4:** Is it possible to check if a male sterilization is working?

**Answer:** Yes, a provider can examine a semen sample under a microscope to see if it still contains sperm. If the provider sees no moving (motile) sperm, the sterilization has been successful. A semen examination is recommended 3 months following the procedure.

**Question 5:** What if my partner gets pregnant?

**Answer:** Please know that male sterilization sometimes fails and your partner could become pregnant as a result. Do not assume your partner was unfaithful if this occurs. Remember to use another contraceptive method during the first 3 months. If possible, visit a provider to obtain a semen analysis and, if sperm are found, repeat the procedure.

**Question 6:** Can the procedure be reversed if I decide I want another child?


**Answer:** Generally no. Male sterilization is intended to be permanent. If you may want more children, please consider nonpermanent contraceptive methods. Surgery to reverse sterilization is possible for only some clients, it is difficult and expensive, and providers who are able to perform such surgery are hard to find. Thus, sterilization should be considered irreversible.

**Question 7:** Is it better for the man to have a male sterilization or for the woman to have female sterilization?

**Answer:** Each client must decide for themselves which method is best for them. Both are effective, safe, permanent methods. However, male sterilization is simpler procedure than female sterilization.

**Question 8:** Will male sterilization increase my risk of cancer or heart disease later in life?

**Answer:** No, evidence shows that male sterilization does not increase risks of cancer (testicular or prostate cancer) or heart disease.



# EMERGENCY CONTRACEPTIVE PILLS (EZY PILL)

## What are emergency contraceptive pills (ECPs)?

Emergency contraceptive pills (ECPs) are oral tablets that contain the hormone progesterone (150 mcg per tablet). They are also commonly known as “the morning after pill” or “postcoital pills.” In select cases, oral contraceptives (i.e., combined oral contraceptives, COCs, and progestin-only pills, POPs) can be used as ECPs; however, as they contain less of the necessary hormone (progesterone) more tablets are required, and therefore they are not practical for use as emergency contraception in most cases.

## How effective are ECPs?

ECPs help to prevent pregnancy when used within 3 to 5\* days of unprotected sex; the sooner, the better (\**according to recent international guidance*). ECPs do not work if a person is already pregnant. Among 100 ECP users, only 1 will become pregnant.

## How do ECPs work?

ECPs inhibit or delay ovulation thus preventing fertilization.

## Who can use ECPs?

ECPs can be taken by any client who has had unprotected intercourse or who has experienced method failure. Clients who are unable to use ongoing hormonal contraceptives may be able to use ECPs because of their short-term nature.

## Who should not use the method?

ECPs should not be taken by any client with an existing pregnancy, as they prevent pregnancies, they do not cause abortions. Otherwise, there are no medical conditions that make ECPs unsafe for any client.

## What are the benefits of ECPs?

- Prevent unwanted pregnancy following unprotected sexual intercourse or method failure
- Available at government health facilities and from community health workers, such as accredited social health activists (ASHAs)
- Available as an over-the-counter medication without prescription
- Enable clients to start using an ongoing contraceptive method



## What are the side effects of ECPs?

The side effects of ECPs include:

- Nausea and vomiting
- Headache
- Dizziness
- Fatigue
- Breast tenderness
- Change in timing of next monthly bleeding (may be earlier or later than expected)

Side effects generally last only a few hours. If a client vomits within 2 hours of taking a pill, another dose is required.

## What are the limitations of ECPs?

- Do not protect against future unprotected sex acts
- Do not protect against STIs, including HIV



## When can clients start using ECPs?

- ECPs should be taken immediately after unprotected intercourse, or as soon as possible, within 3 to 5\* days (*\*according to recent international guidance*)
- COCs or levonorgestrel pills are taken in 2 doses, with the second dose taken after 12 hours

## Do ECP provide protection from STIs, including HIV?

No, ECPs do not provide protection against STIs, including HIV.

## Clarifying Myths and Misconceptions

### Question 1: Do ECPs cause abortion?

**Answer:** No, ECPs do not cause abortion and they do not work if a person is already pregnant. When taken before ovulation, ECPs prevent the release of the egg from the ovary or delay its release by 5 to 7 days. By then, any sperm in the client's reproductive tract will have died, since sperm can only survive there for approximately 5 days.

### Question 2: Do ECPs cause birth defects? Will the fetus be harmed if a client takes ECPs while pregnant?

**Answer:** No. Evidence shows that ECPs do not cause birth defects and will not otherwise harm the fetus. For clients who are already pregnant, ECPs will not prevent or abort an existing pregnancy.

### Question 3: How long do ECPs provide protection against pregnancy?

**Answer:** Clients who use ECPs and are not using another

method may become pregnant the next time they have sex. ECPs delay ovulation, so a client may be fertile soon after taking ECPs. Clients desiring ongoing protection from pregnancy, should start using another contraceptive method immediately.

**Question 4:** Are ECPs safe for adolescents and youth?

**Answer:** Yes. A study among clients aged 13 to 16 found ECPs to be safe for this population. Further, all study participants were able to use ECPs correctly.

**Question 5:** Can a client who cannot use COCs or POPs as an ongoing method still safely use ECPs?

**Answer:** Yes, because ECP use is brief.

**Question 6:** If ECPs fail to prevent a pregnancy, does a client have a greater risk of having an ectopic pregnancy?

**Answer:** No. There is no evidence to suggest that ECPs increase the risk of ectopic pregnancy. Worldwide studies, including a US Food and Drug Administration review, have not found higher rates of ectopic pregnancy after ECP failure as compared to pregnancies generally.

**Question 7:** Can ECPs be used as a regular method of contraception?

**Answer:** No. Nearly all other contraceptive methods are more effective in preventing pregnancy. A client who uses ECPs regularly for contraception is more likely to have an unintended pregnancy than a client who uses another contraceptive method. Still, clients using other methods of contraception should know about ECPs and how to obtain them if needed, for example, in the case of method failure (e.g., a condom breaks or missed pills).

**Question 8:** Can a client buy ECPs over the counter and use them correctly?

**Answer:** Yes. ECPs are simple to use and do not require medical supervision. Studies show that both young and adult clients find the label and instructions easy to understand. ECPs are approved for over-the-counter sales and nonprescription use in many countries.



# POSTPARTUM FAMILY PLANNING

## What is postpartum family planning (PPFP)?

Postpartum family planning (PPFP) is the initiation of FP method use following childbirth.

## When does fertility return after childbirth?

Postpartum clients may become fertile again following childbirth as follows:

- *If not fully or nearly fully breastfeeding*, a client may become pregnant as soon as 4 to 6 weeks after delivery.
- *If fully or nearly fully breastfeeding*, a client may become pregnant as soon as 6 months after delivery.

*Healthy timing and spacing of pregnancy (HTSP):* To achieve the healthiest pregnancy outcomes for baby and mother, a client should wait until the baby is at least 2 years old before trying to conceive again.

## When should pregnant and postpartum clients receive FP counseling?

1. *During antenatal care:* Integrating FP counseling with antenatal care allows sufficient time for clients to be counseled and to make decisions free of the stresses associated with delivery. This also helps to ensure that clients can receive their method of choice immediately after delivery.
2. *During early labor, before delivery:* A client may be counseled in early labor, if she is comfortable and able to concentrate on the information provided. The stress that clients experience just before delivery may impair decision-making capabilities and counseling clients should be postponed if they are under such stress. The provider is responsible for ensuring clients make informed, voluntary, and sound decisions.
3. *After delivery, before discharge.* While it may be too late to provide the client's preferred method at the time of or immediately following delivery without prior planning, providers can help ensure that a client receive their method of choice before discharge or is scheduled to return for follow-up care to access their preferred method.

## How early can clients begin using PFP methods?

For maximum protection, postpartum clients should not wait until monthly bleeding returns to start a FP method, but should instead start as soon as current guidance allows.

The table below summarizes current guidance around the timing for initiating PFP.

Method	Earliest time that a client can start a method after delivery	
	Fully/nearly fully breastfeeding	Not breastfeeding
<b>Combined oral contraceptives (COCs)</b>	After 6 months	After 3 weeks
<b>Weekly oral pills</b>	Immediately, as directed	Immediately, as directed
<b>Injectable contraceptives</b>	After 6 weeks	Immediately, as directed
<b>Condoms (male or female)</b>	Immediately	Immediately
<b>Copper IUCD</b>	Within 48 hours or after 4* to 6 weeks	Within 48 hours or after 4* to 6 weeks
<b>Female sterilization</b>	Within 7 days (only minilap) or after 6 weeks	Within 7 days (only minilap) or after 6 weeks
<b>Male sterilization</b>	Immediately or during partner's pregnancy	Immediately or during partner's pregnancy
<b>Progestin-only pills (POPs)</b>	Immediately, as directed	Immediately, as directed
<b>Hormonal IUCDs</b>	Within 48 hours or after 4 weeks	Within 48 hours or after 4 weeks

Method	Earliest time that a client can start a method after delivery	
	Fully/nearly fully breastfeeding	Not breastfeeding
<b>Lactational amenorrhea method (LAM)</b>	Immediately	Not applicable
<b>Fertility awareness methods (FAM)</b>	When normal secretions have returned (symptoms-based methods) or after 3 regular menstrual cycles (calendar-based methods)	When normal secretions have returned (symptoms-based methods) or after 3 regular menstrual cycles (calendar-based methods)
<b>Implants</b>	Within 6 months, if monthly bleeding has not returned	Within 4 weeks or after 4 weeks* once reasonably certain the client is not pregnant (*a backup method is required for 7 days following insertion)

\* According to recent international guidance



# POSTABORTION FAMILY PLANNING

## What is postabortion family planning (PAFP)?

Postabortion family planning (PAFP) is the initiation of contraceptive methods during management of an abortion (induced or spontaneous) or before fertility returns after the abortion or miscarriage.

## How soon does fertility return after an abortion?

*Fertility:* Fertility returns quickly, within 10 to 11 days following a first trimester abortion and within 4 weeks of a second trimester abortion. Therefore, the need for contraception begins almost immediately.

*Spacing between abortion and next pregnancy:* To achieve the healthiest pregnancy outcomes for both baby and mother, clients should wait at least 6 months before trying to conceive again.



## When should abortion clients receive FP counseling?

Abortion clients' needs vary, based on their personal circumstances; for example, they may be experiencing physical (e.g., pain), emotional (e.g., anxiety or stress), and practical (a need to return home to care for other children or household responsibilities) challenges associated with the pregnancy and abortion. Providers need to assess the best timing for FP counseling for these clients on a case-by-case basis.

Counseling *before the procedure* is only appropriate if the client is not under stress. If there are signs of stress, any counseling and associated decision-making of the client should be postponed until the next appropriate opportunity but before discharge from the facility. This is because the ability to comprehend information and make an informed decision may be impaired if the client is experiencing stress.

The next appropriate opportunity for PAFP counseling is *after the procedure*, when the client is comfortable, but before discharge from the facility. While it may be too late to provide the client's method of choice immediately after the procedure is completed, (for example, in the case of IUCD), providers can help ensure that clients are able to receive their methods of choice before discharge or are scheduled to return for follow-up care to access their preferred methods.

## How should abortion clients be counseled?

Abortion clients may be counseled as follows:

*Before the abortion procedure:* Check that the client's physical condition and emotional situation is appropriate

for PAFP counseling. Explain the benefits of healthy timing and spacing of pregnancy (HTSP) and the importance of waiting at least 6 months after an abortion before trying to conceive again. Discuss available PAFP methods as well as ways of reducing risk of STIs, including HIV.

*After the abortion procedure:* Once the client is physically and emotionally comfortable, but before discharge, provide PAFP counseling. Again, check the client's condition, explain the importance of waiting to conceive, and discuss available methods, including those which may require a return visit for follow-up care.

### How early can clients begin using PAFP methods?

For maximum protection, abortion clients should not wait until monthly bleeding returns to start a FP method, but should instead start as soon as current guidance allows. The table below summarizes current guidance around the schedule for initiating PAFP.

Method	Earliest time that a client can start a method after an abortion
Combined oral contraceptive (COCs)	Immediately
Weekly oral pills	Immediately
Injectable contraceptives	Immediately
Condoms (male or female)	Immediately

Method	Earliest time that a client can start a method after an abortion
Copper IUCD	Immediately, after confirming a complete abortion and excluding or resolving any infection or injury to the genital tract
Female sterilization	Concurrently or within 7 days, if the client is eligible
Male sterilization	Immediately
Progestin-only pills (POP)	Immediately
Hormonal IUCD	Within 7 days, after confirming a complete abortion and excluding or resolving any infection or injury to the genital tract; after 7 days, after ruling out pregnancy and infection (requires backup method for 7 days following insertion)
Implant	For first and second trimester abortions: Concurrently, in the case of a manual vacuum aspiration or during the second part of a medical abortion (i.e., with Misoprostol) or within 7 days; after 7 days, a backup method is needed





# **Other Family Planning Methods**



# FEMALE CONDOMS

## What is a female condom?

A female condom is a thin, flexible pouch with a soft, flexible ring on each end. Female condoms are made of silicone-coated polyurethane, latex, or nitrile. The female condom is inserted before sex to prevent pregnancy and STIs, including HIV. The female condom looks slightly different from the male condom. It is 17 cm long with a 6 cm diameter ring at inner closed end, which helps stay in place.



## How effective are female condoms?

Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used properly. When used correctly, female condoms are 95% effective in preventing

pregnancy, compared with male condoms, which are 98% effective. However, statistics show that, due to incorrect usage, female condoms are 79% effective.

### How do female condoms work?

The female condom serves as a barrier, blocking semen (and sperm) from entering the vagina, thereby preventing pregnancy. They also prevent infections in semen, on the penis, or in the vagina from infecting the other partner. They can be inserted up to 8 hours before intercourse.

### Who can use a female condom?

All clients can use female condoms to protect against pregnancy and STIs, including HIV.

### What are the benefits of female condoms?

- Safe, simple, and convenient
- Provide dual protection against pregnancy and STIs
- Female-controlled
- Can be used during menstrual periods and during the early postpartum period
- Can be used with spermicide
- Can be inserted up to 8 hours in advance
- Does not need to be removed immediately after intercourse
- Can be used by people with latex allergies



- Can be used with silicone- and water-based lubricants
- Male sensation may remain more consistent during intercourse than with male condoms
- Nonhormonal (does not affect a client's hormones)
- Does not require a male erection to use or stay in place
- Fewer chances of rupture during use than male condoms
- Does not usually require a visit to a healthcare provider

### What are the challenges associated with using female condoms?

Some clients may experience:

- Vaginal, vulvar, anal, or penile discomfort or irritation
- Allergic reaction (rare)

Additionally, female condoms are less discreet than other forms of contraceptive and may:

- Slip inside the body during intercourse
- Reduce sexual sensation
- Produce minimal noise during intercourse
- Be distracting during foreplay
- Be more expensive than male condoms
- Be harder to find than male condoms
- Require practice to use correctly

## Do female condoms provide protection from STIs, including HIV?

Used correctly, female condoms offer protection from STIs, including HIV. Female condoms also cover a wider area than male condoms, thereby providing additional protection from infections affecting a larger portion of the genital area, including the labia, perineum, and base of the penis.

## How are female condoms used?

*Tips for safe and effective use of female condoms include:*

- Store condoms in a cool, dry place.
- Read the instructions and check the expiration date.
- Check the condom for tears and defects before use.
- Use a lubricant to prevent slipping and tearing.
- Insert the condom before engaging in each and every sexual activity.

*Steps for inserting a female condom:*

1. Wash hands with soap and clean water before insertion.
2. Select a position that is comfortable for insertion, such as squatting, raising a leg, or sitting or lying down.
3. Carefully open the condom package without damaging the condom.
4. Rub the sides of the condom together to spread the lubricant evenly.
5. With one hand, grasp the inside ring at the closed end and squeeze it to make the ring long and narrow.

6. With the other hand, separate the outer vaginal lips (labia).
7. Gently push the inner ring into the vagina as far you can, then insert a finger into the condom to push it further into place.
8. Ensure approximately 2 to 3 cm of the condom and the outer ring remain outside the vagina.
9. During sexual intercourse, ensure the penis enters the condom by carefully guiding the tip inside the condom. If, during sexual intercourse, the condom is accidentally pulled out of or pushed fully inside the body, pause and reposition the condom.
10. Remove the condom before standing (to avoid spillage) by holding the outer ring, twisting the condom to seal in the fluid, and gently remove. Dispose of the condom by wrapping in its package and placing in a trash bin.

*Never do any the following:*

- Never use a male condom with a female condom, as the friction may cause one or both condoms to tear.
- Never reuse a condom after removing it from the body.
- Never flush a condom as they can clog a drain and cause environmental damage.

For any additional questions about female condoms, including how to use them, and if they are the right choice, speak with a healthcare provider.

## Where are female condoms available?

Female condoms are available over the counter and online.

## Clarifying Myths and Misconception

### Question 1: Are female condoms difficult to use?

**Answer:** No, but they do require some practice and patience during initial period.

### Question 2: Can I use male and female condoms together?

**Answer:** No, do not use male and female condoms together. The friction may cause one or both condoms to tear.

### Question 3: Can I use any lubricants with female condoms?

**Answer:** Yes. Both oil and water-based lubricants (such as baby oil, body lotion, cooking oil, glycerine, Vaseline, etc.) can be used with female condoms, as compared to only water-based lubricants with male condoms.

### Question 4: Can the female condom be used more than once?

**Answer:** No. Insert a new female condom for each sex act.

### Question 5: Does the larger size of female condoms (compared to male condoms) make them uncomfortable to use during sexual intercourse?

**Answer:** No. Female condoms are the same length as male condoms, just wider. They are made of flexible materials that fit to the shape of the vagina. Female condoms are carefully designed and tested to fit any client, regardless of the size of the vagina or penis.

### Question 6: Will the inner ring of the female condom hurt me during sexual intercourse?

**Answer:** The inner ring of the female condom is strong but not hard, and flexible, to keep it in place during intercourse. However, if it is not inserted properly into the vagina, you may experience some discomfort. If that happens, pause and reposition or reinsert the condom, ensuring that inner ring is tucked behind the pubic bone.

**Question 7:** If the female condom is pushed inside my body, can it enter or hurt my uterus.

**Answer: No.** The female condom fits outside the cervix, covering the external part of cervix, and is completely separated from the uterus. It is not possible for female condom to travel inside the uterus; therefore, there is no chance of it entering or damaging the uterus.

**Question 8:** Can I use a female condom during my monthly bleeding?

**Answer:** Yes. You can use the female condom safely during your monthly bleeding; it does not interfere with menstruation. You may find it useful for sex during your menses, as the inner ring with the pouch acts as a barrier to the blood flow and enables sexual intercourse without the interference of monthly bleeding.

**Question 9:** Can I use female condoms for different sexual positions?

**Answer:** Yes, you can use female condoms for different positions, but more lubricant may be needed for some.

**Question 10:** Does the female condom provide more protection against STIs than the male condom?

**Answer:** The protection against STIs is largely the same for both the female and male condoms. However, female condoms provide more coverage of the external parts of female genitalia and of the penis base and scrotum, thus providing additional protection from some STIs that are transferred via skin-to-skin contact.

**Question 11:** Can I use the female condom during pregnancy or during postpartum period?

**Answer:** Yes, you can safely and effectively use the female condom during pregnancy and the postpartum period.

**Question 12:** Can I use female condom without my partner's knowledge?

**Answer:** While a client may insert a female condom alone, part of the female condom will remain outside the vagina and be visible to your partner.

# PROGESTIN-ONLY PILLS

## What are progestin-only pills (POP)?

Progestin-only pills (POPs), also known as “minipills,” are oral tablets containing low doses of the hormone progesterone. Unlike combined oral contraceptives (COCs), POPs do not contain estrogen.



## How effective are POPs?

POPs are highly effective, if taken as directed. With typical use, about 1 pregnancy occurs per 100 clients in the first year. With proper use, effectiveness is 99.7%; effectiveness falls to 97% with typical use. In other words, the failure rate with typical use is 3% and in proper use it is 0.3%.

## How do POPs work?

POPs work by thickening the cervical mucus to prevent sperm from entering the uterus and by preventing the release of eggs from the ovaries.

## Who can use POPs?

Clients who want an effective, reversible method can use POPs. Clients of all ages, including adolescents and those over 40, those who are breastfeeding, and those who have previously had an abortion can all use POPs.

## Who should not use POPs?

POPs should not be taken by any clients who:

- Has an acute blood clot in the deep veins of legs or the lungs
- Has a history of breast cancer
- Has severe liver disease, infection, or tumor
- Has systemic lupus erythematosus
- Is taking medication for seizures or tuberculosis

## What are the benefits of POPs?

- Reversible, easy to use, and safe for most clients
- Can be started soon after childbirth
- Can be used while breastfeeding, in fact POPs are more effective during breastfeeding (99% effective)
- Do not interfere with sexual intercourse



- Available from trained nonmedical staff
- Immediate return of fertility upon discontinuation

### What are the limitations of POPs?

The limitations of POPs include:

- Effectiveness decreases when breastfeeding stops
- Requires regular, dependable supply
- Does not protect against STIs, including HIV

### What are side effects of POPs?

Common side effects include:

- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea

Other potential side effects include:

- Changes in bleeding patterns, including irregular and/or prolonged bleeding or no bleeding
- Prolonged postpartum amenorrhea (among breastfeeding clients)
- Enlarged ovarian follicles (among non-breastfeeding clients)

## When can clients start using POPs?

POP can be started any time it is reasonably certain that the client is not pregnant, following the guidance below.

- Clients starting within 5 days of the start of their monthly bleeding do not need a backup method. Clients starting more than 5 days after the start of monthly bleeding need to use a backup method for the first 2 days.
- Postabortion clients may start immediately. Postabortion clients starting within 7 days do not need a backup method; while those starting more than 7 days after need to use a backup method for the first 2 days.
- Fully or partially breastfeeding clients may start any time between birth and 6 months, assuming monthly bleeding has not returned.

## How to use POPs?

- Take 1 pill every day at the same time of day (or within 3 hours) to ensure effectiveness.
- After finishing a pack of pills, begin a new pack immediately.

## How should a client manage missed pills?

If 3 or more hours late in taking a pill:

- Take the missed pill as soon as possible.
- Keep taking pills as usual, 1 each day (may take 2 pills at the same time or on the same day, if necessary).

- For clients with regular monthly bleeding: Use a backup method for the next 2 days and, consider taking ECPs if there has been unprotected sex in past 3 days.
- For clients who have vomited within 2 hours following a pill: Take another pill as soon as possible, and keep taking pills as usual.

## Do POPs provide protection from STIs, including HIV?

No, POPs do not provide protection from STIs, including HIV.

## Clarifying Myths and Misconceptions

### Question 1: I am breastfeeding, are POPs safe for me?

**Answer:** Yes. POPs are good for breastfeeding clients to use as they are safe for both mother and baby, may be started immediately after birth, and do not affect milk production.

### Question 2: Can I continue taking POPs when I stop breastfeeding?

**Answer:** Clients who are satisfied with using POPs can continue using them after having finished breastfeeding, although POPs provide less protection against pregnancy after stopping breastfeeding. There are other oral contraceptives as well as other contraceptive methods that a client may also consider after stopping breastfeeding.

### Question 3: Do POPs cause birth defects? Will my fetus be harmed if I accidentally take POPs while I am pregnant?

**Answer:** No. Evidence shows that POPs do not cause birth defects and will not otherwise harm the fetus if a client

becomes pregnant while taking POPs or accidentally takes POPs when already pregnant.

**Question 4:** How long does it take to become pregnant after stopping POPs?

**Answer:** Fertility returns immediately after discontinuing use of POPs. A client's bleeding pattern prior to using POPs generally returns soon after discontinuation, although some clients may wait a few months before their usual bleeding pattern returns.

**Question 5:** I did not have my monthly bleeding and I am using POPs, does this mean that I am pregnant?

**Answer:** Probably not, especially if you are breastfeeding. If you have been taking your pills every day, you are probably not pregnant; however, you may consider taking a pregnancy test. If not having your monthly bleeding causes you concern, and you are not pregnant, consider switching to another method (other than the injectables).

**Question 6:** Do POPs cause cancer?

**Answer:** No. Studies to date, while limited, have not demonstrated any increased risk of cancer among POP users. Additionally, larger studies of implants (used in other countries), which contain twice the dose of similar hormones, have not shown any increased risk of cancer.

**Question 7:** Will POPs change my mood or sex drive?

**Answer:** Generally, no. There is no evidence that POPs affect sex drive. While some POP clients report these complaints, the majority of users do not report any such changes. Contrarily, some clients report improvements in both mood

and sex drive; however, it is difficult to determine whether such changes are due to POP use or to other reasons.

**Question 8:** Do POPs increase my risk of ectopic pregnancy?

**Answer:** No. POPs reduce the risk of ectopic pregnancy by preventing any pregnancy. Further, in the event that POPs fail, ectopic pregnancies are rare among POP users and the majority of pregnancies after POP failure are not ectopic.

# HORMONAL INTRAUTERINE CONTRACEPTIVE DEVICE

## What is the hormonal intrauterine contraceptive device (IUCD)?

The hormonal intrauterine contraceptive device (IUCD) is a small, flexible, plastic T-shaped device containing the hormone levonorgestrel, or LNG. It is also commonly known as LNG IUCD. The hormone is steadily released at the rate of 20 mcg per 24 hours through a rate-controlling membrane over a period of 5 years.



## How effective is the hormonal IUCD?

The hormonal IUCD is one of the most effective long-term, reversible contraceptive methods. The effectiveness rate is less than 1 pregnancy per 100 clients in the first year (2 pregnancies per 1,000 clients) and over 5 years, remains

less than 1 pregnancy per 100 clients (5 to 8 pregnancies per 1,000 clients).

### How does the hormonal IUCD work?

The hormonal IUCD works through endometrial suppression and by altering cervical mucus and utero-tubal fluid, which prevents sperm migration.

### Who can use the hormonal IUCD?

The hormonal IUCD is a safe and effective contraceptive method for nearly all clients.

### Who should not use the hormonal IUCD?

The hormonal IUCD should not be used by clients who:

- Are 48 hours postpartum; it may be inserted earlier than 48 hours or after 4\* to 6 weeks (*\*according to recent international guidance*)
- Have a history of blood clots in the legs and/or lungs
- Have severe liver diseases or liver tumor(s)
- Have a history of breast cancer

### What are the benefits of the hormonal IUCD?

- Highly effective (99.8%)
- Long-acting and convenient: once inserted, provides protection for 5 years without further user actions
- Immediate return of fertility after removal
- Corrects dysmenorrhea

- Reduces dysfunctional uterine bleeding (approximately 90% of bleeding stops within the first few months following insertion)
- Reduces symptoms of endometriosis
- Has no estrogenic side effects

### What are the side effects of the hormonal IUCD?

- Clients may experience changes in monthly bleeding patterns (e.g., irregular, infrequent, and/or lighter bleeding; fewer days of bleeding; and/or no monthly bleeding). These changes will lessen within the first 3 to 6 months of insertion.
- Clients may experience minimal weight gain (approximately 2.4 kg over 5 years).
- Other minor side effects include acne, headaches, and breast tenderness.
- There is a small risk of infection or of IUCD expulsion, perforation, or displacement.

### When can a client start using a hormonal IUCD?

1. *Clients with regular monthly bleeding*
  - May be inserted within 7 days of monthly bleeding
  - May be inserted any time during the menstrual cycle after ruling out pregnancy; if starting after 7 days, requires a backup method for 7 days following insertion
2. *Clients switching from another contraceptive method*
  - If switching from a nonhormonal method, guidance remains the same as for clients with regular monthly bleeding



- If switching from a hormonal method:
  - ▶ From oral contraceptives: May be inserted immediately, if the method has been used consistently and correctly, otherwise rule out pregnancy prior to insertion
  - ▶ From injectable contraceptives: May be inserted when repeat dose is due; requires a backup method for 7 days

### 3. *Postpartum clients*

- Non-breastfeeding: Within 48 hours of delivery
- Fully breastfeeding: After 4 weeks, following the guidance below:
  - ▶ *No monthly bleeding: May be inserted any time between 4 weeks to 6 months after delivery*
  - ▶ *Monthly bleeding has returned: May be inserted following guidance for clients with regular monthly bleeding*
  - ▶ *More than 6 months postpartum: If monthly bleeding has not returned, may be inserted any time after ruling out pregnancy but requires a backup method for 7 days; if monthly bleeding has returned, follow guidance for clients with regular monthly bleeding*
- Partially breastfeeding:
  - ▶ Less than 4 weeks postpartum with no monthly bleeding: Any time after ruling out pregnancy; requires a backup method for 7 days

- ▶ After monthly bleeding has returned: Follow guidance for clients with regular monthly bleeding

#### 4. *Amenorrheic clients*

- May be inserted any time after ruling out pregnancy; requires a backup method for 7 days

#### 5. *Postabortion and miscarriage clients*

- May be inserted within 7 days of first and second trimester abortions, after excluding or resolving any infections
- May be inserted after 7 days, after ruling out pregnancy and excluding or resolving any infections; requires a backup method for 7 days

#### 6. *Clients who recently used emergency contraception*

- May be inserted within 7 days of monthly bleeding
- May be inserted any time after 7 days, after ruling out pregnancy; requires a backup method for 7 days

## Clarifying Myths and Misconceptions

### **Question 1:** Can the hormonal IUCD cause an abortion?

**Answer:** No, the hormonal IUCD cannot cause an abortion of an existing pregnancy. It can only prevent pregnancy and should not be used to cause an abortion.

### **Question 2:** Do I risk developing cancer in any part of my body if I use the hormonal IUCD?

**Answer:** There is no evidence to date that using the hormonal IUCD will increase the risk of cancer in the breasts, ovaries,

uterus, or any other parts of the body. In fact, the hormonal IUCD protects against endometrial cancer.

**Question 3:** If the hormonal IUCD fails and I become pregnant, will it harm the baby?

**Answer:** No, if the hormonal IUCD fails, it will not harm to the baby. However, it is advisable to have the device removed if you become pregnant.

**Question 4:** If I have the hormonal IUCD, will I be able to safely have multiple sexual partners?

**Answer:** The hormonal IUCD does not protect against STIs. Therefore, it is advisable to also use condoms (in addition to your IUCD) to protect you from contracting any STIs.

**Question 5:** Do I need my partner's consent to obtain an IUCD?

**Answer:** No, only your consent is required to obtain an IUCD.

**Question 6:** Can I see the hormonal IUCD before it is inserted?

**Answer:** Yes. Clients should see and be counseled about the device before consenting to insertion. Clients are also required to be given an IUCD insertion card specifying the name and date of the insertion, as this information will be referenced during follow-up care and removal.

**Question 7:** Are there any medications that might interfere with my hormonal IUCD?

**Answer:** No, there is no current evidence of medications interfering with the hormonal IUCD. However, it is always

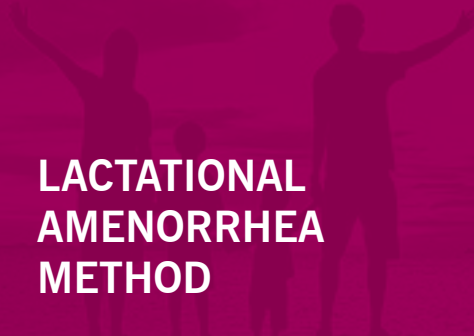
best to tell your doctor that you have an IUCD before starting any medications in high doses or for prolonged durations.

**Question 8:** Is removing the hormonal IUCD painful or difficult?

**Answer:** No. Normally, there are no problems or pain during the removal procedure. The insertion procedure is more likely to be uncomfortable than the removal procedure.

**Question 9:** If I want to have another child, do I need to wait for a period of time after having my hormonal IUCD removed before trying to conceive?

**Answer:** While fertility may return immediately after removal, it is recommended that clients wait until after the next period to clear the uterus. However, clients who conceive immediately after an IUCD removal are as likely as anyone else to have a normal pregnancy and baby.



# LACTATIONAL AMENORRHEA METHOD

## What is the lactational amenorrhea method (LAM)?

The lactational amenorrhea method (LAM) is a temporary FP method based on the natural effect of breastfeeding on fertility. The word “lactational” relates to breastfeeding and “amenorrhea” refers to not having monthly bleeding. LAM provides contraception for breastfeeding clients whose monthly bleeding has not returned.

## How effective is LAM?

Effectiveness depends on the client, with the risk of pregnancy being greatest among clients who cannot fully or nearly fully breastfeed.

- When used correctly, the failure rate is less than 1 pregnancy per 100 clients in the first 6 months following delivery.
- As commonly used, the failure rate is approximately 2 pregnancies per 100 clients in the first 6 months following delivery.

- The return of fertility varies, depending on how long the client continues to breastfeed.



### How does LAM work?

LAM works by preventing the release of eggs from the ovaries (ovulation). Regular breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

### Who can use LAM?

All clients who meet the following criteria can use LAM:

- Their monthly bleeding has not returned
- They are fully or nearly fully breastfeeding (including feeding often, day and night)

- ▶ Fully breastfeeding includes exclusive breastfeeding (the infant receives no other liquid or food, including water, besides breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients occasionally in addition to breast milk)
- ▶ Nearly fully breastfeeding means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than 3/4 of all feedings) are breast milk
- Their baby is less than 6 months old

### Who should not use LAM?

Clients in the following circumstances should consider other contraceptive methods:

- They do not fulfil the 3 criteria for LAM, for any reason
- They are using certain medications, including mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants

### What are the benefits of LAM?

- Helps prevent pregnancy
- Promotes recommended breastfeeding patterns, with health benefits for both mother and baby

### What are the side effects of LAM?

There are no side effects associated with LAM.

## When can clients start using LAM?

Clients should start breastfeeding immediately (within 1 hour) or as soon as possible following delivery. Clients who have been fully or nearly fully breastfeeding since delivery and whose monthly bleeding has not returned and who are within 6 months of delivery may also use LAM.

## What are the 3 key questions I should ask clients interested in using LAM?

Ask clients the following 3 questions; if they answer “no” to *all* three questions, they may rely on LAM for contraception:

- Has your monthly bleeding returned?
- Are you regularly giving your baby food other than breast milk or are you going for long periods time without breastfeeding, either day or night?
- Is your baby more than 6 months old?

## Does LAM provide protection from STIs, including HIV?

No, LAM does not provide protection from STIs, including HIV.





# FERTILITY AWARENESS METHODS

## What are fertility awareness methods (FAMs)?

“Fertility awareness” means that a client knows how to determine when the fertile time of her menstrual cycle starts and ends. There are several fertility awareness methods (FAMs), which can be used alone or in combination with other methods. This includes calendar-based and symptoms-based methods.

- *Calendar-Based Methods* require clients to track the days of their menstrual cycles to identify the start and end of their fertile period. This may be accomplished in two ways, as follows:
  - ▶ *Standard Days Method:* A client tracks the days of her menstrual cycle, counting the first day of monthly bleeding as day 1, and avoids having unprotected vaginal sex (for example, by using condoms) on days 8 through 19.
  - ▶ *Calendar Rhythm Method:* A client estimates her fertile time by subtracting 18 from the length of her

shortest recorded menstrual cycle and by subtracting 11 from the length of her longest recorded cycle. This indicates the estimated fertile period when she will need to avoid unprotected vaginal sex.

- *Symptoms-Based Methods* require clients to observe signs of fertility and avoid unprotected vaginal sex during this time. This may be accomplished in two ways, as follows:
  - ▶ *Cervical Secretions*: This requires tracking (seeing or feeling) cervical secretions (vaginal wetness), which indicate fertility.
  - ▶ *Basal Body Temperature*: This requires tracking resting body temperature, which increases slightly near the time of ovulation (when an egg is released), indicating fertility. A pregnancy is unlikely to occur 3 days after this temperature increase until the start of monthly bleeding.

### How effective are FAMs?

Effectiveness, assuming correct and consistent use, varies for different types of FAM, as follows: 5 pregnancies per 100 clients in the first year for the standard days method; 9 pregnancies per 100 clients in the first year for the calendar rhythm method; 3 pregnancies per 100 clients in the first year for the cervical secretions method; and 1 pregnancy per 100 clients in the first year for the basal body temperature method. Effectiveness with typical use decreases to 12 pregnancies per 100 for standard days method and 13 pregnancies per 100 for calendar rhythm method; reliable data is not available for cervical secretions and basal body temperature methods.

## How do FAMs work?

FAMs work by helping clients know when they are fertile so that they may avoid having unprotected vaginal sex during that time.

## Who can use FAMs?

All clients can use FAMs, with their partner's cooperation.

## Who should not use FAMs?

No medical conditions prevent the use of FAMs, but some conditions can make them harder to use effectively and necessitate using caution or delaying.

- Using caution means that additional or special counseling may be needed to ensure correct use of the method.
- Delaying means that use of a method should be delayed until a condition is evaluated or resolved.

## Calendar-Based Methods

- *Caution:* The client's menstrual cycles have recently started, have become less frequent, or have stopped
- *Delay:* The client recently gave birth or is breastfeeding; recently had an abortion or miscarriage; is experiencing irregular monthly bleeding; or is using medications that may delay ovulation

## Symptoms-Based Methods

- *Caution:* The client recently had an abortion or miscarriage; her menstrual cycles have recently

started, have become less frequent, or have stopped; or she has a chronic condition that raises body temperature

- *Delay*: The client recently gave birth or is breastfeeding; is experiencing irregular monthly bleeding or abnormal vaginal discharge; is using medications that may affect cervical secretions, raise body temperature, or delay ovulation; or has an acute condition that raises body temperature

### What are the benefits of FAMs?

- No side effects
- Do not require any medical procedures or medications
- Helps clients learn about their bodies and fertility
- Allows some clients to adhere to their religious or cultural norms related to contraception
- Helps clients identify fertile days to both avoid pregnancy as well as to conceive

### What are the side effects of FAMs?

There are no side effects associated with FAMs.

### When should clients start using FAMs?

Once trained, clients can begin using FAMs at any time, following the guidelines below.

- *Clients with regular monthly bleeding*: Begin FAMs at any time. There is no need to wait for the next monthly bleeding.

- *Clients without regular monthly bleeding:* Calendar-based methods cannot be used. Delay symptoms-based methods until regular monthly bleeding returns.
- *Postpartum clients* (including those who are breastfeeding): Delay standard days method until after 3 menstrual cycles; start symptoms-based methods once normal secretions have returned.
- *Postabortion clients:* Delay standard days method until the start of next monthly bleeding. Start symptoms-based method immediately, with special counseling and support.
- *Clients switching from a hormonal method:* Delay standard days method until the start of next monthly bleeding. Start symptoms-based methods in the next menstrual cycle after stopping a hormonal method.
- *Clients who recently used emergency contraception:* Delay standard days method until the start of next monthly bleeding. Start symptoms-based methods once normal secretions have returned.

## What information should be shared with clients interested in FAMs?

### Calendar-Based Methods

- *Standard Days Method:* This method may be used if most of the client's menstrual cycles last between 26 to 32 days. Track the days of your menstrual cycle, counting the first day of monthly bleeding as day 1, and avoid having unprotected vaginal sex (for example, by using condoms) on days 8 through 19, which are considered fertile days for all users of this method.

Consider using color-coded beads or a calendar as memory aid.

- *Calendar Rhythm Method:* Before relying on this method, record the number of days in each of your menstrual cycles for at least 6 months. The first day of monthly bleeding is always counted as day 1. Begin to estimate the fertile period by subtracting 18 from the length of the shortest recorded cycle; this indicates the first day of your fertile period. Then, subtract 11 from the length of your longest recorded cycle; this indicates last day of your fertile time. Avoid unprotected vaginal sex during the fertile period. Update these calculations each month, always using the 6 most recent cycles to calculate fertility periods.

### Symptom-Based Methods

- *Cervical Secretion:* Check daily for any cervical secretions on your finger, underwear, or tissue paper, or by sensation in the vagina. Avoid unprotected vaginal sex on days of heavy bleeding when it is difficult to check mucus. Between the end of monthly bleeding and the start of secretions, you can have unprotected sex, but not for 2 days in a row. (Avoiding intercourse on the second day allows time for semen to disappear and for cervical mucus to be observed.) As soon as you observe any secretions, consider yourself fertile and avoid unprotected vaginal sex. Continue to check cervical secretions each day. The secretions have a “peak” day, which is the last day that they are clear, slippery, stretchy, and wet. You will know that this has passed when, on the next day, your secretions are sticky or dry, or you have no secretions at all. Continue

to consider yourself fertile for 3 days after that peak day and avoid unprotected vaginal sex. You can have unprotected sex again on the fourth day after your peak day and until your next monthly bleeding begins. If you have a vaginal infection or other condition that affects your cervical mucus, it will be difficult to use this method effectively.

- *Basal Body Temperature:* Take your body temperature at the same time each morning before getting out of bed and before eating anything. Record your temperature on a special graph. Watch for your temperature to rise slightly (approximately 0.2° to 0.5°C or 0.4° to 1.0°F) near the time of ovulation (usually midway through your menstrual cycle). Avoid unprotected vaginal sex beginning on the first day of your monthly bleeding and until 3 days after your temperature has risen above your normal temperature. You can have unprotected sex beginning on the fourth day and until your next monthly bleeding. If you experience a fever or other changes in body temperature, it will be difficult to use this method effectively.



# CONTRACEPTIVE IMPLANTS (IMPLANON NXT)

## What is a contraceptive implant?

A contraceptive implant is a soft, flexible rod containing the hormone progestogen (68 mg etonogestrel) in a slow-release carrier made of ethylene vinyl acetate, which is inserted subdermally (under the skin). Implants release approximately 60 to 70 mcg of progestogen each day; the rate slowly decreases over time. Implanon NXT (brand name) implants also contain barium sulphate, which is radio-opaque and can be visualized under X-ray.

## How effective are implants?

Contraceptive implants are more than 99% effective for both perfect and typical use.

## How do implants work?

The progestogen in contraceptive implants prevents ovulation (the release of eggs from the ovaries) and thickens cervical mucus to prevent sperm from entering the uterus.



## What are the benefits of implants?

- Highly effective (99%)
- Long-acting and convenient: once inserted provides protection for up to 3 years without further user action
- Safe for breastfeeding clients
- Does not interfere with sexual intercourse
- Steady release of hormones ensures there is no initial peak, thus metabolic changes are minimal
- Estrogen-free: may be used by clients who cannot use estrogen-containing contraceptives
- Corrects anemia and dysmenorrhea
- Prevents endometrial cancer
- Decreases incidence of pelvic inflammatory disease
- Immediate return of fertility after removal

## What are the side-effects of implants?

- Changes in menstrual bleeding, including infrequent or prolonged bleeding, or no monthly bleeding (common)
- Acne, headache, abdominal pain, breast tenderness, nausea, dizziness, mood and weight changes (common)
- Itching and/or infection at the insertion site, migration from or expulsion from the insertion site (rare)

## Who can use implants?

Any client seeking a long-term, effective, reversible, convenient contraceptive method can use implants.

## Who should not use implants?

Clients with any of the following should not use implants:

- Acute liver disease or liver adenomas
- Recent history of breast cancer or current cancer anywhere in the body
- Unexplained vaginal bleeding
- History of ischaemic heart disease, including stroke
- History of using hepatic enzyme-inducing drugs

## When can clients have implants inserted?

1. *Clients regular monthly bleeding*
  - May be inserted any day between day 1 and 5 of the menstrual cycle
  - After day 5 of the menstrual cycle: May be inserted any time after ruling out of pregnancy; requires a backup method for 7 days following insertion
2. *Clients switching from another contraceptive method*
  - If switching from a copper IUCD: May be inserted immediately after removal of the IUCD
  - If switching from injectable contraceptives: May be inserted when the next injection is scheduled
  - If switching from any other hormonal methods: May be inserted immediately, if the hormonal method is

used consistently and correctly; otherwise rule out pregnancy prior to insertion

### 3. *Postpartum clients*

- Fully breastfeeding:
  - ▶ No monthly bleeding: May be inserted any time between 4 weeks and 6 months after delivery
  - ▶ Monthly bleeding has returned: May be inserted following guidance for clients with regular monthly bleeding
- Partially breastfeeding:
  - ▶ No monthly bleeding: Rule out pregnancy before insertion; requires a backup method for 7 days
  - ▶ Monthly bleeding has returned: May be inserted following guidance for clients with regular monthly bleeding
- Non-breastfeeding:
  - ▶ May be inserted any time after delivery until 6 weeks postpartum
  - ▶ After 6 weeks, if monthly bleeding has returned, rule out pregnancy prior to insertion; requires a backup method for 7 days

### 4. *Amenorrheic clients*

- May be inserted any time after ruling out pregnancy; requires a backup method for 7 days

### 5. *Postabortion and miscarriage clients*

- For first and second trimester abortions: Concurrently, in the case of a manual vacuum

aspiration or during the second part of a medical abortion (i.e., with Misoprostol) or within 7 days; after 7 days, requires a backup method for 7 days

## Where and how are implants inserted and removed?

*Insertion:* Implants are normally inserted approximately 8 to 10 cm above the medial epicondyle of the humerus in the nondominant upper arm (the left arm for right-handed persons). Implants are inserted subdermally, following a local anesthesia, using a specially designed applicator comprising a needle loaded with the implant. After fully inserting the applicator needle in the correct place, an unlock knob slides down to release the implant. Pressure will be applied to the insertion site for 2 minutes to prevent excessive bleeding and then a small bandage will be applied. After insertion, the provider will ensure the device is in the correct position.

*Removal:* After giving a local anesthesia, a small incision is made near the lower palpable end of the implant. Small, mosquito straight forceps are inserted and used to grab the lower end and gently remove the implant from the subdermal space, ensuring that the entire implant is removed. The provider will show the removed implant to the client before discarding it. If the client wishes to continue with this method, the provider will insert the new implant through the same incision.

## Clarifying Myths and Misconceptions

**Question 1:** Will other people be able to see my implant?

**Answer:** The implant is not usually noticeably visible, but you may be able to feel it under your skin with your fingers.

**Question 2:** Can the implant get lost in my arm?

**Answer:** Unlikely. Soon after the implant is inserted, a small layer of tissue will form around it, keeping it in place and preventing movement.

**Question 3:** What is the different between Implanon NXT and other implants?

**Answer:** Implanon NXT is a single rod device with barium sulphate, whereas other implants contain either 6 or 2 rods and do not have any radio-opaque material.

**Question 4:** How long I can use implants?

**Answer:** A single implant will prevent pregnancy for 3 years. However, you can continue use by having a provider insert a new implant after removing the old implant every 3 years for as long as you want.

**Question 5:** When do I need to discontinue the implant, if I want to conceive?

**Answer:** Fertility returns within one week of removal.

**Question 6:** Will the implant affect my menstrual cycle?

**Answer:** Yes. Most clients experience some changes in their monthly cycles: some have irregular periods, some have none, while others find that their periods are heavier and last longer. This is normal and does not affect effectiveness.

**Question 7:** Will my arm continue to hurt after the implant is inserted?

**Answer:** Implants usually do not hurt after insertion. In fact, the area where the implant is inserted is covered with fat and tissue, which can make the implant difficult to feel at times.

**Question 8:** Are follow-up visits required after insertion?

**Answer:** No, routine follow-up visits are not necessary for implant users. However, clients should attend annual wellness visits for preventive care and also return for any questions or problems.

**Question 9:** Do implants cause birth defects in case of method failure and accidental pregnancy?

**Answer:** No. Several studies have shown that implants do not cause birth defects and will not otherwise harm the fetus if an implant user becomes pregnant.

**Question 10:** How soon can I return to work or school after insertion?

**Answer:** You will be able to return to school or work immediately after leaving the clinic following insertion, as long as you are careful not bump the insertion site or to get it wet.

# FAMILY PLANNING METHODS FOR ADOLESCENTS AND YOUTH

## Who are considered adolescents and youth?

The World Health Organization defines “adolescents” as individuals aged 10 to 19 years and “youth” as those aged 15 to 24 years. The term “young people” includes both adolescents and youth, covering the individuals aged 10 to 24 years.

## Do adolescents and youth need special care during FP service delivery?

All adolescents and youth should be treated with respect and dignity when accessing any kind of sexual and reproductive healthcare services, including contraceptive care. The first step is to welcome clients, ensure audio-visual privacy, and explain and confirm confidentiality. In addition to contraceptive care, young people may also need other forms of sexual and reproductive healthcare, including counseling and services related to the prevention of and screening and treatment for reproductive tract infections

and STIs. Adolescents and youth may also have questions about the physical and emotional changes associated with puberty, interpersonal relationships, and similar issues. Carefully consider your body language, tone, and word choice to provide respectful, nonjudgmental care and services. Provide opportunities for adolescents and youth to ask questions and to share any fears or concerns; then, respond with easy-to-understand, factual information, correcting any myths or misinformation. Do not criticize any young person for seeking information or services and remember to ensure full, free, informed choice.

### Which FP methods are safe for young people?

All FP methods are safe for adolescents and youth, regardless of marital status and parity. It is important to discuss all available methods that respond to their needs and their possible side effects. This will help ensure young people are able to make free, full, and informed choices about which method is best for them—recognizing that young people are experts in their own bodies and their own lives. Understanding that adolescents and youth may be at increased risk of contracting STIs, including HIV, compared to older clients, it is also important to explain dual method use and protection.

### Are there any special considerations for young people related to specific FP methods?

When counseling adolescents and youth about FP methods, it is important to explain method use as well as any side effects, limitations, and risks as part of standard counseling



practices. A few additional considerations for counseling young people include:

*Oral contraceptives (COCs, weekly pills, and POPs):* Safe and effective for young people when taken as directed

*Injectables:* Safe and effective for young people when taken as directed (with healthcare visits every 3 months)

*Male and female condoms:* Protect against STIs, including HIV, as well as pregnancy (dual protection); may be combined with other short- and long-acting methods

*IUCDs (copper and hormonal):* Safe and effective for young people but may be more likely to be expelled, particularly among nulliparous clients, due to smaller uterus size

*Female and male sterilization:* Reference eligibility criteria

*ECPs:* Young clients may have less control over sex and contraception than older clients, resulting in an increased need for ECPs; ECPs may be provided in advance

*LAM:* May be appropriate for breastfeeding clients

*FAM:* May be challenging for adolescents and youth who are still establishing regular menstrual cycles; this should be conveyed through clear and comprehensive counseling

*Contraceptive implants:* Safe and effective for young people, with a single insertion effective for 3 years



# COUNSELING: THE REDI APPROACH

EngenderHealth's REDI framework offers a comprehensive approach to counseling for contraception, building upon EngenderHealth's extensive leadership on rights, choice, and voluntarism in sexual and reproductive health (SRH). The REDI framework, which leverages knowledge gained through more than 30 years of counseling training experience, has been honed over the past 15 years through programming in more than a dozen countries. The most recent update to the REDI framework, including the new REDI curriculum, offers an approach to counseling training that places the client at the center and empowers health providers to help each new client choose the method of contraception that is best suited to their unique personal situation, social circumstances, and SRH needs. For return clients, REDI emphasizes correct usage and method satisfaction.

Personalization and customization are pinnacles of modern life; yet, when it comes to SRH choices, which are among the most important and personal of decisions anyone can make, counseling often takes a one-size-fits-all approach. Historically, providers have tended to assume that the best way to serve a client is to provide comprehensive information about all contraceptive methods available and let the client choose. This frequently results in one-directional, provider-centered communication that overwhelms the client with too much information and leaves too little time for the relationship-building and two-way communication that allow clients to make the best choices for their unique situations.

Providers are often reluctant to ask about personal factors affecting the clients' decisions, such as the nature of their sexual relationships or their communication with their partners about pregnancy prevention and the risks associated with STIs, including HIV. Additionally, clients frequently lack the opportunity to consider the challenges that they may encounter in implementing their decisions, which means they may make decisions that are unrealistic or even dangerous for them to implement, which often leads to early discontinuation.

REDI offers a new, 4-day curriculum for training health providers. This program leverages years of experience to address the aforementioned challenges and to enable providers to help clients make full, free, and informed decisions that:

- Consider the client's individual circumstances and social and gender contexts

- Emphasize the client's rights to and responsibilities for making and implementing decisions
- Identify the challenges a client may face in implementing SRH decisions and develop strategies and skills to address those challenges

## Defining REDI

REDI stands for:

- Rapport Building
- Exploring
- Decision Making
- Implementing the Decision

This framework incorporates learning and best practices from around the world and applies that knowledge to create a new client-centered approach to SRH counseling.



## How REDI Overcomes Traditional Counseling Barriers

Here's how REDI shifts traditional approaches to ensure counseling leads to more effective results.

Common Problem	REDI Approach
<ul style="list-style-type: none"><li>● Provider-centered, one-directional communication</li></ul>	<ul style="list-style-type: none"><li>● Client-centered, two-way communication in which the provider focuses on identifying the client's individual needs</li></ul>
<ul style="list-style-type: none"><li>● Similar treatment of new and return clients; no differentiation between return clients who are satisfied and those who are dissatisfied</li></ul>	<ul style="list-style-type: none"><li>● Two distinct pathways provide detailed guidance for new and return clients</li><li>● Providers employ different approaches for return clients who are satisfied with their method and those who are dissatisfied</li></ul>
<ul style="list-style-type: none"><li>● Lack of understanding of clients' personal or social situations, such as the nature of their sexual relationships or their communications with partners about pregnancy prevention and risks of STIs/HIV</li></ul>	<ul style="list-style-type: none"><li>● Exploration of clients' sexual relationships and communications with partners about pregnancy prevention and the risks associated with STIs, considering gender and social factors that influence decisions</li><li>● Targeted guidance responding to clients' unique circumstances and SRH intentions</li></ul>

Common Problem	REDI Approach
<ul style="list-style-type: none"> <li>● Little to no discussion regarding the challenges or barriers clients may encounter implementing their decisions, which often leads to early discontinuation</li> </ul>	<ul style="list-style-type: none"> <li>● Clients develop specific implementation plans for using the method effectively</li> <li>● Clients identify challenges to implementing their decisions and develop strategies for overcoming those challenges</li> </ul>

## Overview: The REDI Framework

The REDI framework consists of 4 phases, as summarized herein.

### Phase 1: Rapport Building

1. Greet client with respect.
2. Make introductions and identify the category of the client (i.e., new, satisfied return, or dissatisfied return client).
3. Assure confidentiality and privacy.
4. Explain the need to discuss sensitive and personal issues.
5. Use communication skills effectively (this is applicable in all phases).

## Phase 2: Exploring

Identify the reason for the visit.

### *For new clients:*

1. Individual factors: Explore the client's SRH history and pregnancy prevention goals.
2. Other key factors: Explore the client's sexual relationships, social and gender contexts for decision making, and risk of STIs, including HIV.
3. Explain pregnancy prevention and other SRH options, focusing on the method(s) of interest to the client, addressing individual and other key factors.

### *For return clients:*

1. Explore the client's satisfaction with the current method.
2. Confirm correct method use.
3. Ask the client about any life changes (e.g., plans to have children and STI risks and status)

### *For dissatisfied clients:*

1. Explore the reasons for the client's dissatisfaction, including identifying the issue, its causes, and possible solutions, such as switching methods.

## Phase 3: Decision Making

1. Summarize findings from the Exploring phase:
  - Identify the decisions the client needs to make or confirm (for satisfied return clients, see if they need other services; if not, move to Phase 4, Step 4).

- Identify relevant options for each decision (e.g., pregnancy prevention and STI/HIV risk reduction).
  - Confirm medical eligibility for any contraceptive methods that the client is considering.
2. Help the client consider the benefits, disadvantages, and consequences of each method of interest and provide information to address any remaining knowledge gaps.
  3. Confirm that any decision the client makes is informed, well-considered, and voluntary.

#### Phase 4: Implementing the Decision

1. Assist the client in developing a specific plan for implementing their decision(s) (e.g., obtaining and using the contraceptive method chosen, risk reduction for STIs, dual protection, etc.).
2. Identify barriers that the client may face in implementing their decision and plan.
3. Develop strategies to overcome identified barriers.
4. Create a follow-up plan, providing referrals, as needed.

#### The REDI Training Methodology

The REDI curriculum uses the blended learning approach, where trainees study knowledge content before attending in-person training. This allows for more time during the training for discussion and for trainees to practice their attitudes and skills. The curriculum includes manuals for trainers and trainees, as well as presentation slides to be used throughout the training, making it easy to implement.



The curriculum is available at [www.engenderhealth.org/counseling](http://www.engenderhealth.org/counseling). Please contact EngenderHealth at [info@engenderhealth.org](mailto:info@engenderhealth.org) for support in incorporating the REDI framework into your program.



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